Appendix 17
Orthodontic Services

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
08110	Removable appliance therapy, minor treatment for tooth guidance	Yes	< 21	HealthCheck referral required.
08120	Fixed appliance therapy, minor treatment for tooth guidance	Yes	< 21	HealthCheck referral required.
08210	Removable appliance therapy	Yes	< 21	HealthCheck referral required.
08220	Fixed appliance therapy	Yes	< 21	HealthCheck referral required.
08360	Interceptive orthodontic treatment, removable appliance therapy	Yes	< 21	HealthCheck referral required.
08370	Fixed appliance therapy, interceptive orthodontic treatment	Yes	< 21	HealthCheck referral required.
08560	Monthly treatment - comprehensive orthodontic treatment - permanent dentition, Class I malocclusion	Yes	< 21	HealthCheck referral required.
08570	Monthly treatment - comprehensive orthodontic treatment - permanent dentition, Class II malocclusion	Yes	< 21	HealthCheck referral required.
08580	Monthly treatment - comprehensive orthodontic treatment - permanent dentition, Class III malocclusion	Yes	< 21	HealthCheck referral required.

Appendix 17
Orthodontic Services
(continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
08650	Monthly treatment of atypical or extended skeleton cases, orthodontic	Yes	< 21	HealthCheck referral required.
W7910	Examination, models, consultation - orthodontic	Yes	< 21	HealthCheck referral required.
W7920	Initial orthodontic treatment - banding service	Yes	< 21	HealthCheck referral required.
08750	Post-treatment stabilization	Yes	< 21	HealthCheck referral required.

Appendix 17
Orthodontic Services
(continued)

COVERED SERVICES

DEFINITION

Orthodontic services are covered for interceptive orthodontic services to minimize future malocclusion during the developmental phases of the mixed dentition and to provide comprehensive orthodontic service due to handicapping malocclusion causing speech, eating/ mastication, or psychological problems.

HEALTHCHECK REQUIREMENT

Orthodontia treatment is available only through the HealthCheck program and is not available to adults over age 20 (the HealthCheck provider signature is required).

RECIPIENT ELIGIBILITY FOR COMPLETION OF ORTHODONTIC TREATMENT

Regardless of recipient eligibility, all approved orthodontic services, once started (bands placed during a period of eligibility) are reimbursed to completion of the approved services performed by a certified provider.

If an orthodontia patient becomes Medicaid-eligible in mid-treatment, Wisconsin Medicaid will approve a prior authorization (PA) request for continued services if all PA criteria are met.

FIXED OR REMOVABLE APPLIANCE THERAPY SERVICES

MINOR TOOTH GUIDANCE

This service is for correction of a minor malocclusion in which one to four teeth are involved. The service is considered especially for children under the age of 12 in the mixed dentition stage of development.

HARMFUL HABIT CORRECTING

This service is for correction of harmful habit such as thumb, finger, tongue or lip sucking and is considered especially for children under the age of 12 in the mixed dentition stage of development.

If this procedure is coordinated with any behavioral modification, either by the dentist or by another health care provider, it must be documented on the PA request.

INTERCEPTIVE ORTHODONTIC TREATMENT

This service is for the correction of a minor malocclusion in which one to four teeth are involved and is considered especially for children under the age of 12 in the mixed dentition stage of development. The correction of cross bites, orthopedic orthodontics, and 2 x 4 interceptive procedures are allowed services under this procedure. Interceptive procedures are not inclusive of permanent teeth Phase II orthodontic treatment of this malocclusion.

PRIOR AUTHORIZATION

GENERAL REQUIREMENTS

All orthodontic services require PA and a HealthCheck referral. For orthodontic records reimbursement, the following guidelines are applicable: examination, models, cephalometric x-ray, panoramic x-ray, or consultation are reimbursed if there is a HealthCheck exam (the HealthCheck provider signature is required). These procedures may be reimbursed even if the remaining orthodontic treatment is denied. Orthodontic services are not available to adults over age 20.

Appendix 17
Orthodontic Services
(continued)

Procedure W7910 (examination models, consultation—orthodontic) includes an examination of the recipient, a consultation, and the obtaining of study models. This procedure must be performed and an orthodontic treatment plan must be included with any PA request for orthodontic treatment. Although this procedure requires PA, the procedure must be done to obtain PA. The PA request will be backdated to include date of record.

Before submitting a PA request for any orthodontic treatment, the provider must:

- Perform a clinical examination of the patient.
- Obtain orthodontic study models.
- Complete the PA dental request forms (PA/DRF and PA/DA).
- Submit the models with the PA request for orthodontic services.
- Obtain a written, signed verification that a HealthCheck exam has occurred. It must be dated within one year of the date the PA request is received by the fiscal agent.

SEVERE MALOCCLUSION CRITERIA FOR APPROVAL

The criteria for approving orthodontia are summarized below:

- A severe and handicapping malocclusion determined by a minimum Salzmann Index of 30.
- In extenuating circumstances, the dental consultant may, after comprehensive review of the case, determine that a severe handicapping malocclusion does exist and approve the orthodontia treatment even though the Salzmann score is less than 30.
- Transfer cases from out-of-state or within state must fulfill Medicaid criteria of age and Salzmann Index at time of initial treatment (banding).
- Certain cases of minor treatment (1-4 teeth) can be approved for minor fixed or removable orthodontic treatment
- If the request for orthodontic services is the result of a personality or psychological problem or condition and a patient does not meet the criteria listed above, then a referral from a mental health professional is required.

A copy of the Salzmann Index can be obtained by writing to:

Provider Maintenance
EDS
6406 Bridge Road
Madison, WI 53784-0006

Orthodontic treatment is *not* authorized for cosmetic reasons.

TERMINATED ORTHODONTIC TREATMENT

If any orthodontic treatment is terminated prior to completion, the provider must notify the prior authorization unit in writing within 30 day of termination. The notification must include the reason(s) for termination and treatment progress notes. This must be done before a new dentist can get a PA.

Appendix 17
Orthodontic Services
(continued)

ORTHODONTIC INITIAL TREATMENT AND BILLING DATE

When billing for the initial orthodontic banding service, the date used is the day the treatment started. This is defined as the date when the bands, brackets, or appliances are placed in the recipient's mouth. The recipient must be Medicaid eligible on this date of service.

RETAINERS

Providers can request retainers as part of any comprehensive orthodontic service. If retainers are separately identified on an approved PA for orthodontic service, they may be separately reimbursed. However, when submitting the PA request, the provider may normally include the placement, fees, and follow-up for retainers in the initial fee and monthly adjustments. In this case, a separate request for retainers will not be granted. Using either way of billing, the maximum fee for orthodontic treatment will be the same.

LOST OR DAMAGED RETAINERS

In the cases of lost or damaged retainers, the provider should submit a new PA request for a new retainer. New orthodontic records do not need to be submitted with the new PA. However, multiple lost retainers (due to recipient negligence) will *not* be replaced.

The following documentation must be submitted with all requests for orthodontic PA:

1. Orthodontic records of the exam, consultation, and study models. Study models must be securely packed, clearly labeled to identify the provider and the recipient, and must include a centric occlusion bite registration.
2. A completed PA/DRF.
3. Signed and dated evidence that a HealthCheck exam has occurred in the past year.
4. A treatment plan.

Although not covered by Wisconsin Medicaid, intraoral camera-ready photographs *may* be included in the request.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered orthodontic services, procedure codes, and related limitations.
- Appendix 31 of this handbook for a summary of required billing documentation.
- Appendix 24 of this handbook for a summary of required documentation needed for PA requests.

Appendix 18
Adjunctive/General Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
Unclassified Treatment:				
09110	Palliative (emergency) treatment of dental pain - minor procedure	No	All	Not billable immediately before or after surgery.[3] *Emergency only.*
Anesthesia:				
09220	General anesthesia	Yes	All	Prior authorization not required for place of service 1, 2, B. Prior authorization not required in an emergency. Not billable with 09240.
09240	Intravenous sedation	Yes	All	Prior authorization not required in an emergency or for place of service 1, 2, or B. Not billable with 09220.
Professional Visits:				
09420	Hospital call	Yes	All	Up to two visits per stay. Only allowable in place of service 1, 2, B. Prior authorization not required in an emergency.
Miscellaneous Services:				
09910	Application of desensitizing medicament	No	All	Tooth numbers 1-32, A-T, SN. Limit of $50 reimbursement per day for all emergency procedures done on a single day. Not billable immediately before or after surgery.[3] Cannot be billed for routine fluoride treatment. *Emergency only.*

- Refer to Endodontic Services, Appendix 12 of this handbook, for information on W7116 - Open Tooth for Drainage.
- Refer to Periodontic Services, Appendix 13 of this handbook, for information on W7117 - Treat ANUG and W7118 Treat Periodontal Abscess.

Key:

[3] - $50 limitation per day for all emergency procedures applies to 09110, 09910, W7116, W7117, and W7118. Narrative required to override the limitations.

Appendix 18
Adjunctive/General Services
(continued)

COVERED SERVICES

DEFINITION

Adjunctive general services include hospitalization, general anesthesia, intravenous sedation, and emergency services provided for relief of dental pain.

PALLIATIVE (EMERGENCY) TREATMENT

For Wisconsin Medicaid purposes, palliative (emergency) treatment is treatment of dental pain - minor procedures that do not fit into the restorative, periodontic, or oral and maxillofacial surgery covered services described in this handbook. Refer to Section II-A of this handbook for a detailed explanation of emergency services. Palliative treatment and definitive treatment cannot be performed on the same tooth on the same date of service.

INPATIENT AND OUTPATIENT HOSPITAL SERVICES

Inpatient and outpatient hospitalization is allowed on an emergency and non-emergency (elective) basis for all dental services.

Hospitalization for the express purpose of controlling apprehension is not a Medicaid-covered service. This policy applies to inpatient or outpatient hospital and ambulatory surgical centers.

Non-emergency hospitalization is appropriate in the following situations:

- Children with uncontrollable behavior in the dental office or with psychosomatic disorders that require special handling. Children needing extensive operative procedures such as multiple restorations, abscess treatments, or oral surgery procedures.
- Developmentally disabled recipients with a history of uncooperative behavior in the dental office, even with premedication.
- Hospitalized recipients who need extensive restorative or surgical procedures or whose physician has requested a dental consultation.
- Geriatric recipients or other recipients whose medical history indicates that monitoring of vital signs or that the availability of resuscitative equipment is necessary during dental procedures.
- Medical history of uncontrolled bleeding, severe cerebral palsy, or other medical conditions that render in-office treatment impossible.
- Medical history of uncontrolled diabetes where oral and maxillofacial surgical procedures are being performed.
- Extensive oral and maxillofacial surgical procedures are being performed (e.g., Orthognathic, Cleft Palate, TMJ surgery).

If the request for hospitalization is for an institutionalized recipient, a physician's statement or order and an informed consent signed either by the recipient or the recipient's legal guardian is required.

PRIOR AUTHORIZATION

GENERAL REQUIREMENTS

General anesthesia or intravenous sedation requires prior authorization (PA) except when it is provided in an inpatient hospital, outpatient hospital, or an ambulatory surgical center.

Appendix 18
Adjunctive/General Services
(continued)

GENERAL ANESTHESIA AND INTRAVENOUS SEDATION

The criteria for approval of a PA include:

- A physician's statement indicating the recipient is allergic to local anesthetics.
- The recipient is unmanageable and belligerent with premedication attempts.
- Medical history indicates surgical procedures would require the monitoring of vital signs.
- Medical history of uncontrolled bleeding.
- The request is accompanied with elective major oral and maxillofacial surgery requiring general anesthesia.
- Inability to gain local anesthesia after the recipient has been on antibiotic therapy to control infection for five to seven days or if a life-threatening infection is present.

General anesthesia and intravenous conscious sedation administered by a dental provider is separately billable and requires PA. General anesthesia and intravenous conscious sedation is not allowed simply to control apprehension, even when providing emergency services. Intravenous sedation includes pharmacological management.

NON-EMERGENCY HOSPITALIZATION FOR DENTAL SERVICES

All elective, non-emergency hospital services require PA if they require PA in other places of service, unless otherwise noted.

Hospital calls are limited to two visits per stay and require PA.

EMERGENCY HOSPITALIZATION AND OUTPATIENT DENTAL SERVICES

Emergency hospitalizations and emergency outpatient services (emergency room and day surgery) do not require PA.

BILLING

EMERGENCY SERVICES

Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, *all claims for emergency services must be identified by an "E"* in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted.* Information relating to the definition of a dental emergency is in Section II-A of this handbook.

Claims submitted electronically use a different field to indicate an emergency. Refer to your Electronic Media Claims (EMC) manual for more information.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered adjunctive/general services, procedure codes, and related limitations.
- Appendix 31 of this handbook for a summary of required billing documentation.
- Appendix 24 of this handbook for a summary of required documentation needed for PA requests.